

Blue Care® Elect (PPO) \$3,000 Deductible Option Fact Sheet

Network: Blue Cross and Blue Shield PPO Network (includes local BlueCard® PPO networks)

Access: Members must use providers in the BlueCard PPO network to receive in-network level of benefits. Out-of-network benefits also available.

Acceptable Product Combinations*:

Blue Care Elect (PPO) \$3,000 Deductible Option may be offered alongside the HMO Blue® High Deductible Options.

Blue Care Elect (PPO) \$3,000 Deductible Option has a minimum Massachusetts enrollment requirement of 51%.

* Combinations are representative (not exhaustive) acceptable product combinations for 5-50 eligible employee accounts.

BENEFIT DESIGN	MEMBER'S COST IN-NETWORK (AFTER DEDUCTIBLE)	MEMBER'S COST OUT-OF-NETWORK (AFTER DEDUCTIBLE)
Routine checkups (one per calendar year)	\$15 per visit (no deductible)	20% co-insurance
Well-child visits (age-based schedule)	\$15 per visit (no deductible)	20% co-insurance
Routine GYN exam (one per calendar year), including related lab tests	\$15 per visit (no deductible)	20% co-insurance
Emergency room visits	No charge	No charge
X-rays, laboratory tests, and other imaging tests	No charge	20% co-insurance
Routine vision exams (one exam per calendar year)	\$15 per visit (no deductible)	Not covered
Preventive dental for children under age 12	Not covered	Not covered
Short-term rehabilitation therapy (up to 100 visits per calendar year combined in and out-of-network)	\$15 per visit	20% co-insurance
Ambulatory day surgery in an office setting	\$15 per visit	20% co-insurance
Durable medical equipment (up to \$1,500 per calendar year combined in- and out-of-network)	Charges beyond \$1,500 maximum	20% co-insurance and charges beyond \$1,500 maximum
Physician, podiatrist, and chiropractor office visits for medical care	\$15 per visit	20% co-insurance
Inpatient care	No charge	20% co-insurance
Prescription drug benefit (overall deductible does not apply) At designated retail pharmacies: (up to a 30-day supply for each prescription/refill or supply)	The first \$250 of covered charges per calendar year, then: \$10 for generic* \$20 for preferred brand-name \$35 for non-preferred	
Through mail service drug program (up to a 90-day supply for each prescription/refill or supply)	\$20 for generic* \$40 for preferred brand-name \$70 for non-preferred	

* In a few instances, a generic drug or supply may be covered with a copayment other than the lowest copayment level.

Deductible: \$3,000 per member / \$7,500 per family calendar-year deductible for most in-network and out-of-network benefits.

There is a separate \$250 calendar-year prescription drug deductible for drugs purchased at designated retail pharmacies.

Co-insurance maximum: \$3,000 per member / \$6,000 per family calendar-year co-insurance maximum for out-of-network benefits only.

Lifetime maximum: None.

Blue Care Account: Members have an annual allowance funded by their employer and administered by Wells Fargo Flex Benefits Services to reimburse them directly for covered out-of-pocket medical expenses. Some of the expenses they can be reimbursed for include the deductible for covered medical services, physicians' office visit copayments, and co-insurance for out-of-network covered services.

This fact sheet provides a brief list of Blue Care Elect (PPO) \$3,000 Deductible Option benefits. Benefits are fully described in the Subscriber Certificates and applicable riders. Please contact your sales executive for a copy of the certificates and riders.

Blue Care® Elect (PPO) \$3,000 Deductible Option Fact Sheet (continued)

BENEFIT DESIGN	MEMBER'S COST IN-NETWORK (AFTER DEDUCTIBLE)	MEMBER'S COST OUT-OF-NETWORK (AFTER DEDUCTIBLE)
Mental Health and Substance Abuse Treatment		
Biologically-based conditions**		
Inpatient admissions in a general hospital or mental hospital	No charge	20% co-insurance
Outpatient visits	\$15 per visit	20% co-insurance
Non-biologically-based mental conditions (includes drug addiction and alcoholism)		
Inpatient admissions in a general hospital	No charge	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	No charge	20% co-insurance
Outpatient visits (up to 24 visits per calendar year)	\$15 per visit	20% co-insurance
Alcoholism treatment (in addition to non-biologically-based mental conditions)		
Inpatient admissions in a general hospital	No charge	20% co-insurance
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	No charge	20% co-insurance
Outpatient visits (up to 8 visits per calendar year)***	\$15 per visit	20% co-insurance

**Treatment for rape-related mental or emotional disorders and treatment for children under age 19 is covered to the same extent as biologically-based conditions.

*** The value of these visits is at least \$500 in each calendar year.

Deductible: \$3,000 per member / \$7,500 per family calendar-year deductible for most in-network and out-of-network benefits. There is a separate \$250 calendar-year prescription drug deductible for drugs purchased at designated retail pharmacies.

Co-insurance maximum: \$3,000 per member / \$6,000 per family calendar-year co-insurance maximum for out-of-network benefits only.

Lifetime maximum: None.

Blue Care Account: Members have an annual allowance funded by their employer and administered by Wells Fargo Flex Benefits Services to reimburse them directly for covered out-of-pocket medical expenses. Some of the expenses they can be reimbursed for include the deductible for covered medical services, physicians' office visit copayments, and co-insurance for out-of-network covered services.

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